

Example of PAR approved by SEP

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY
AND FINANCING

Colorado Medicaid
Long Term Home Health
Prior Authorization Request (PAR) Form

					PAR/Invoice/Agency Number	
1. Client State ID Number Y000000	2. Client Name (Last, First, Middle Initial) Smith, John J.	3. County Number 16	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	5. Birth Date (MM/DD/CCYY) 09/13/1936		
6. Service Start Date (MM/DD/CCYY) 07/16/2001	7. Service End Date (MM/DD/CCYY) 07/15/2002	8. Client Address (Street, City, State, ZIP Code) 222 North Street, Denver, CO 80202			9. Client Phone Number (303) 555-1212	
				For Authorizing Agent Use Only		
10. Services Requested	11. Revenue Code	12. # Units Requested	13. Unit Rate	14. # Units	15. Total \$	16. Approved/Pended/Denied
Nursing	551	18	71.42	18	1286.56	A
Home Health Aide - Basic Units	571	730	31.66	730	23111.80	A
Home Health Aide - Extended Units	579	1460	9.46	1460	13811.60	A
Physical Therapy	421					
Occupational Therapy	431					
Speech Therapy	441					
				Total:	\$38,208.96	
17. Client's Case Status <input checked="" type="checkbox"/> (1) New Admit <input type="checkbox"/> (2) Ongoing <input type="checkbox"/> (3) Re-Admit		18. Client's Living Arrangements <input checked="" type="checkbox"/> (1) Client's Home or Home of Relative/Other Person <input type="checkbox"/> (2) Alternative Care Facility <input type="checkbox"/> (3) Foster Care (For Children or Adults) <input type="checkbox"/> (4) Other Group Home <input type="checkbox"/> (5) Other - Please Explain:				
19. EPSDT Request <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		20. Primary Diagnosis Code from ICD-9-CM 344.1				
21. Referral Codes and Discharge Codes - Check "R" before Referral Code on Admits or Re-Admits. Check "D" before Discharge Codes for Discharges - Do not use for ongoing cases						
R D <input type="checkbox"/> (01) Alternative Care Facility <input type="checkbox"/> (02) Adult Foster Care <input type="checkbox"/> (03) Community Centered Board <input type="checkbox"/> (04) Supported Living Services <input type="checkbox"/> (05) Death <input type="checkbox"/> (06) Home Care Allowance <input type="checkbox"/> (07) HCBS/Brain Injury	R D <input type="checkbox"/> (08) HCBS/Developmentally Disabled <input type="checkbox"/> (09) HCBS/Elderly, Blind and Disabled <input type="checkbox"/> (10) HCBS/Mentally Ill <input type="checkbox"/> (11) HCBS/Persons Living With AIDS <input type="checkbox"/> (12) Hospice <input type="checkbox"/> (13) Hospital	R D <input type="checkbox"/> (14) Medicaid Home Health <input type="checkbox"/> (15) Medicare Home Health <input type="checkbox"/> (16) Mental Health Agency <input type="checkbox"/> (17) Moved Out of State <input type="checkbox"/> (19) Nursing Facility <input type="checkbox"/> (20) Other - Explain:	R D <input type="checkbox"/> (21) Personal Care Boarding Home <input type="checkbox"/> (22) Private Duty Nursing <input type="checkbox"/> (23) Self/Family <input type="checkbox"/> (24) Children's Medical Waiver <input type="checkbox"/> (25) Children's HCBS <input type="checkbox"/> (26) Children's Extensive Support <input checked="" type="checkbox"/> (27) Physician			
22. Primary Care Physician (PCP) Name Dr. Jones		23. PCP Phone Number (303) 222-1234		24. PCP Provider Number 09876543		
25. Home Health Agency Name and Address Any Home Health Agency 111 R Street Denver, CO 80202				26. Home Health Agency Phone Number (303) 222-4321		
27. Home Health Agency Signature Mary A. Agency		28. Date Signed 07/01/01		29. Home Health Agency Provider Number 33333333		
Authorizing Agency Representative Signature - Please <i>print</i> name next to Signature Joe Repp, Case Manager Joe Repp		SEP ID # 02349876		Date 07/16/01		
30. Narrative statement of reason(s) for all denied unit(s)				Denials are based on the following Medicaid Regulation(s):		